



**Arkansas Department of Health  
Arkansas State Board of Acupuncture &  
Related Techniques**

4815 W. Markham ST., Slot 69 • Little Rock, AR 72205-3867  
(501) 671-1569 • asbart@arkansas.gov

**ASBART COMPLAINT FORM**

Please print or type the following information and return to the address above.

**Person Registering Complaint**

*Anonymous complaints will not be accepted*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you a licensee? Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, your license number: \_\_\_\_\_

Is this complaint being filed on behalf of any agency or employer? If yes, explain below.

Yes: \_\_\_\_\_ No: \_\_\_\_\_

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**Person Complaint Is Being Registered Against**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Address (If known): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number (If known): \_\_\_\_\_

**Any Other Person(s) With Firsthand Knowledge Of Your Complaint**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address (If known): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Have you reported this complaint to any other regulatory authority? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, name of other regulatory agency(s): \_\_\_\_\_

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**Basis Of Complaint**

Please give a complete statement of facts regarding the violation, including specific details such as names of people involved, dates, location, particulars about the alleged violation(s), and any other pertinent facts including any supporting documents. If more space is needed, please attach additional paper.

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**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I ATTEST THAT ALL STATEMENTS MADE BY ME IN RELATION TO THIS COMPLAINT ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**